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SMMGP

Substance Misuse Management in General Practice

URINE SCREENING

The Task Force Report to Review Services for Drug Misusers (1) recommends that 'Purchasers should ensure that GPs have straightforward access to urine testing facilities.' Do you have these ? How difficult is it to get urine toxicology in your area? We have recently reduced the process from 4-6 weeks to 10 days, but if we really want them to be a useful tool is this acceptable?

Drugs and approximate figures of detection times in urine:

Heroin / morphine	1-3 days (possible only one day)
Methadone	1-2 days (very dose dependent)
Dihydrocodeine	4-5 days (in high concentrations)
Codeine	2-3 days
Pholcodeine	10-15 days
Amphetamines	1-2 days (can be detected up to 4 days)
Cocaine	12 hrs - 3 days
Benzodiazepines	1 day - 3 weeks (acute v. chronic use)
Barbiturates	days - weeks (dependant on type)
Cannabis : casual	2 -7 days
heavy	up to 30 days
Ecstasy	2-4 days
Temgesic	2-3 days
Alcohol	12 - 24 hours

N.B.1. Initial screens are now done by immunoassay which lack the specificity of the older chromatograghic techniques. As a result a positive opiate immunoassay may not find a low level of morphine when present with other metabolites.

2. The methadone assay is designed to detect just the parent drug and not the metabolite - hence the detection time is short and can be used to check taking a daily dose.

What factors influence the time that drugs are going to be detected in the urine?

The drug, the amount taken, whether this was a single dose or chronic use, or taken with other drugs or alcohol (enzyme inducer metabolising and removing the prime drug faster).
The concentration of the urine (the reason why a creatinine is done at the same time)

What does urine testing tell us ?

The range of drugs being used. It is a qualitative result not a quantitative measure (i.e. we don't know if using on top or selling part of the script). We don't know if drug use is increasing or decreasing by comparing urines. It can tell us if the drug user is dependent - opiates persist in urine up to 24 hours / methadone up to 48 hours . If urine is negative and no clinical evidence of withdrawing the user is not dependent.

When to do drug screening urines ?

1. When a drug user presents even if you are not going to prescribe as a useful base line or for comparison in the future
2. Before starting a substitute prescription to confirm use.
3. Before restarting a script after break or relapse.
4. At random through treatment to check on drug use against stated use (remember quantity not possible)

Why do we test urine at random and before script ?

To help decide on a treatment plan, for OUR medicolegal protection, for the patients protection.
To reduce street diversion and the iatrogenic black market pool ??? To spot the hoarder

When could you start a script without waiting for the result of a positive urine ?

Groin injecting, pregnancy with recent trackmarks, post prison with recent tracks, drug user is ill and withdrawing.

What actions should we take after a urine result ?

1. POSITIVE FOR METHADONE & OPIATE.....DISCUSS SCRIPT WITH USER why using on top ? dose of methadone not enough ? more pleasure from heroin ?
2. POSITIVE FOR METHADONE / NEGATIVE FOR OPIATES...USING SCRIPT
3. POSITIVE FOR OPIATES / NEGATIVE FOR METHADONE..SELLING METHADONE ?
4. NEGATIVE FOR METHADONE.....SWITCH TO DAILY
5. NEGATIVE FOR METHADONE ON DAILY SCRIPT.....STOP SCRIPT
6. POSITIVE FOR SEVERAL OTHER DRUGS WHICH ARE NOT PRESCRIBED.....REASSESS DRUG NEEDS AND GOALS

Prescribing injectable methadone in the community:

A recent paper by Strang et al, suggests we are prescribing too much injectable methadone and methadone tablets in the community (2). They go on to say if injectable methadone is to be prescribed it should be done by the specialist services. Tablets are not recommended because of the risk of injecting them. Very few of the specialist services prescribe injectables, so if we do not prescribe, drug users would have the choice of the street or private prescribers, both of which we have found to be much worse for the health of the user and their level of criminal activity. The next newsletter will be on prescribing injectables in the community. If you would like to comment, or share your experiences please write to us.

References:

1. The Task Force to Review Services for Drug Misusers. Report of an Independent Review of Drug Treatment Services in England. Dept. of Health. April 1996.

2. Strang J, Sheridan J, Barber N. Prescribing injectable and oral methadone to opiate addicts: results from the 1995 national postal survey of community pharmacies in England and Wales. BMJ 1996;313:270-272.

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